

## EDITOR'S PAGE



## Practice Guidelines and Cookbook Medicine—Who Are the Cooks?

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In an era of managed competition, cost-effective medical care becomes a major goal of any health care delivery system. Such a system will generate practice guidelines to accomplish this goal. For example, in our own medical center, the Division of General Internal Medicine has just written guidelines on the proper use of echocardiography in their prepaid and health care populations. Other guidelines are being developed for other diagnostic techniques.

On a larger scale, many organizations are developing practice guidelines or position statements on a whole variety of issues. The ACC/AHA Task Force on Cardiovascular Procedures has published a number of influential practice guidelines. Currently, it is working on revising the guidelines on radionuclide imaging and clinical intracardiac electrophysiologic studies and is developing two new ones—management of heart failure and cardiovascular evaluation for noncardiac surgery.

The ACP/ACC/AHA Task Force on Clinical Privileges in Cardiology is completing three clinical competence statements: Clinical Competence in Invasive Cardiac Electrophysiologic Studies, Competence in Electrocardiography and Clinical Competence in Permanent Pacemaker Implantation. Such statements will have an enormous impact on the practice of cardiology, as, for example, the recent declaration that interventional cardiologists must perform a minimum of 75 procedures/year (1). At the present time, there are also eight position statements and one policy statement under development by ACC committees.

At the March 1994 annual meeting of the ACC, another clinical practice guideline was unveiled to the press and the public: Unstable Angina: Diagnosis and Management. This report was released by the Agency for Health Care Policy Research (AHCPR) and the National Heart, Lung, and Blood Institute (NHLBI), both components of the Public Health Service. The guidelines were put together by 19

experts, with the process managed by Duke University. More than 1,800 studies of unstable angina were considered in developing the guidelines. Copies of the guidelines and accompanying quick reference guides are available without charge from AHCPR Publications Clearinghouse, P.O. Box 8547, Silver Spring, Maryland 20907, tel: (800) 358-9295. It is clear that this excellent document will have an enormous impact on clinical practice. The AHCPR has also developed guidelines on 20 topics as wide ranging as otitis media, human immunodeficiency virus (HIV) illness and Alzheimer's disease. Fourteen additional topics are under current study.

It is clear from the above that we are at only the beginning of an enormous production of practice guidelines from a wide variety of sources, most likely with considerable variability in quality. Will these be eventually compiled in a *Cookbook of Medicine*? How will they be utilized in various health care consortia? Will they become the standard of practice in malpractice cases? All of these questions are of considerable importance because these guidelines could dominate the practice of medicine in the future. Several issues need to be raised, as highlighted by the following questions:

1. **Who are the cooks?** The recent AHCPR guidelines seem to represent a consensus of recognized experts in the field and are a syntheses of the entire medical literature on the subject. These guidelines are likely to remain as authoritative statements in the long run. Similarly, the ACC/AHA practice guidelines and ACP/ACC/AHA clinical competence statements represent important consensus documents with considerable weight. On the other hand, local statements developed by health maintenance organizations (HMOs) may reflect a tendency to keep costs down by avoiding the use of technology that is "expensive." In any areas of uncertainty, outcomes research will be important in establishing the "correctness" of such practice guidelines.

2. **What are the motives of the cooks?** The AHCPR has as its stated mission: "Improve the quality and effectiveness of

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health care, broaden access to services, and reduce health care costs." As long as this goal remains broad, utilizes a large number of recognized experts and does not become preoccupied *only* with costs, its products will most likely remain important and useful.

If a procedure-based group or organization develops guidelines, there may be bias toward utilization of their procedure. At the very least, the mere appearance of a conflict of interest may weaken their conclusions, even though the guidelines are appropriate. The HMOs may be guided so much by cost-saving that their guidelines may underutilize technology. Physicians in these organizations have a different kind of conflict of interest if they are rewarded for how few tests they order.

**3. What is the timeliness of the guidelines?** We have learned that the practice of medicine changes rapidly as new technology emerges and large clinical studies are completed. Thus, practice guidelines have a limited life and must be revised in a timely way as circumstances change. For example, the ACC/AHA Task Force on Cardiovascular Procedures is currently revising two practice guidelines (Radionuclide Imaging and Clinical Intracardiac Electrophysiologic Studies).

**4. How rigid are the guidelines?** Practitioners long ago learned that each patient presents a unique clinical problem and often follows a unique clinical course. Evaluation and treatment must be much more than a cookbook application of published algorithms. A sound understanding of pathophysiology and variations in clinical course will guide the clinician to vary from established algorithms in ways that will greatly benefit the patient. Sound clinical judgment

remains a cornerstone of medical practice and will always be complementary to practice guidelines. The approach to practice guidelines by the ACC/AHA Task Force on Cardiovascular Procedures provides some recognition of this uncertainty principle by dividing indications for procedures into three categories: a) those for which there is consensus agreement; b) those for which there is uncertainty and no general consensus; and c) those applications that are considered to be inappropriate.

**5. What is the scientific basis for the guidelines?** Consensus statements that represent only opinions will clearly be less authoritative than those based on an extensive scientific literature. This is an opportunity for future outcomes research that can incorporate cost-effectiveness with other end points.

In summary, practice guidelines will be a useful and more common yardstick by which to measure physician performance. At the same time we must evaluate these guidelines carefully, especially in the light of the questions raised here. In any evaluation of "cookbook medicine," we must always ask the question, "Who are the cooks?" We must also ask, "What is the cost of the meal?" Because there is no free lunch, someone must pay for continued excellence in medical care. There is little point in having universal access to poor medical care.

## Reference

1. ACC/AHA Task Force Report. Guidelines for percutaneous transluminal coronary angioplasty. *J Am Coll Cardiol* 1993;22:2033-54.